DELTA DENTAL®
Delta Dental Plan of Colorado
PO Box 5468
Denver, Colorado 80217-5468
(303) 741-9300 (800) 233-0860 (Toll Free)
(303) 773-3880 (FAX)
www.deltadentalco.com

ENROLLMENT and STATUS CHANGE FORM

Please **Print** or **TYPE**

Be sure form is completed in full for proper enrollment

EMPLOYEE INFORMATION

1. GROUP NAME:	2. GROUP NUMBER:	3. DATE OF HIRE:	4. EFFECTIVE DATE:

5. SOC. SEC. NO.:	6. DATE OF BIRTH:	7. LAST NAME (Subscriber):	8. FIRST NAME:
- -	/ /		

9. HOME ADDRESS:	10. CITY:	11. STATE:	12. ZIP:

PLAN SELECTION

13. **PLAN:** Select plan you are enrolling in OR plan you are currently enrolled in:

❑ DeltaPremier
❑ DeltaPreferred Option (DPO)
❑ Exclusive Panel Option (EPO)
❑ DeltaCare *If selected, each subscriber & dependent must choose a DeltaCare Dentist.

REASON FOR SUBMISSION (CHECK ONE)

14. **Requested:**

❑ New Enrollment
❑ CHANGE Family Status
{ } Add Dependent(s)
{ } Delete Dependent(s)
❑ CHANGE Name
from _____
to _____
❑ Return from leave
DATE: _____
❑ SWITCH my coverage to:
{ } DeltaPremier
{ } DeltaPreferred Option (DPO)
{ } Exclusive Panel Option (EPO)
{ } DeltaCare

❑ CANCEL Coverage
❑ WAIVE Coverage**
❑ ADDRESS Change
❑ CHANGE to COBRA
❑ Late Enrollment (if applicable)
❑ CHANGE DeltaCare Dentist
❑ CHANGE to Full-time status
DATE: _____
❑ OTHER (explain below)
_____

15. **Reason for Change:** **Date of Event**

❑ Marriage ____/____/____
❑ Birth / Adoption ____/____/____
❑ Divorce ____/____/____
❑ Legal Separation ____/____/____
❑ Death ____/____/____
❑ Employment Terminated ____/____/____
❑ No Longer Eligible ____/____/____
❑ Spouse Lost Coverage ____/____/____
❑ Other: _____ ____/____/____

16. **Select Coverage:**

❑ Employee Only
❑ Employee and Spouse
❑ Employee and Children
❑ Employee and Child
❑ Employee, Spouse and Children

PLEASE LIST ALL DEPENDENT(S) TO BE COVERED

17. ADD	17. DELETE	18. **Last Name** (include if different)	19. **First Name**	20. **Social Security # Required**	21. **Date of Birth**	22. **Sex: M or F**	***DeltaCare enrollment ONLY:** 23. **Dentist & Provider #**
❑	❑	Subscriber		/ /			#
❑	❑	Spouse		/ /			#
❑	❑	Child		/ /			#
❑	❑	2.		/ /			#
❑	❑	3.		/ /			#
❑	❑	4.		/ /			#

** I understand that the terms of the contract between Delta Dental Plan and my employer may not allow late enrollment for me and my dependents, or the contract may allow late enrollment but may require waiting periods or additional limitations.

I authorize payroll deduction, if applicable.

_____ _____
24. **Signature of Employee** Date

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental Plan of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete or misleading facts to Delta participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

For DDPC Use ONLY

Group #	Eff. Date	Billing Code	Subgroup #